2018 Regular Session

HOUSE BILL NO. 690

BY REPRESENTATIVE STOKES

INSURANCE/HEALTH: Provides for coverage for subsequent preventive tests for certain individuals diagnosed with breast cancer

AN ACT

To enact R.S. 22:1077.1 and R.S. 46:975.1, relative to mandatory coverage for subsequent cancer screening services for individuals who received a bilateral mastectomy; to require health insurance coverage for cancer screening services for certain individuals; to require notice of coverage; to prohibit certain acts by health insurance issuers; to designate certain cancer screening services as Medicaid covered services; to provide for applicability; to provide for an effect date; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1077.1 is hereby enacted to read as follows:

§1077.1. Required coverage for preventive cancer screening following a bilateral mastectomy

A. The legislature hereby finds that after women who are diagnosed with breast cancer finish active treatment, they may transition into a different system for long-term survivorship care. An often overlooked, but nonetheless important, component of follow-up care for cancer survivors is screening for new primary cancers.

B.(1) Any health benefit plan delivered or issued for delivery in this state shall include coverage for preventive cancer screening for a qualified covered person on no less than an annual basis.

(2) The coverage provided in this Section may be subject to annual deductibles, coinsurance, and copayment provisions as are consistent with those established under the health benefit plan.

(3) Written notice of the availability of coverage pursuant to this Section shall be delivered to the insured or enrollee upon enrollment and annually thereafter as approved by the commissioner of insurance.

C.(1) Any health benefit plan offered by a health insurance issuer shall provide notice to each insured or enrollee under the plan regarding the coverage required by this Section in accordance with regulations adopted by the Department of Insurance.

(2) The notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted in one of the following ways, whichever is earlier:

(a) In the next mailing made by the plan or issuer to the insured or enrollee.

(b) As part of any annual informational packet sent to the insured or enrollee.

D. A health benefit plan offered by a health insurance issuer shall not do any of the following:

(1) Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this Section.

(2) Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or nonmonetary incentives to an attending provider, to induce the provider to provide care to an insured or enrollee in a manner inconsistent with this Section.

(3) Reduce or limit coverage benefits to a patient for the preventive services performed pursuant to this Section as determined in consultation with the attending physician and patient.

E. For purposes of this Section:

(1) "Health benefit plan" means any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract, or other agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type in this state, including a group insurance plan, a self-insurance plan, and the Office of Group Benefits programs. "Health benefit plan" shall not include a plan providing coverage for excepted benefits as defined in R.S. 22:1061 and short-term policies that have a term of less than twelve months.

(2) "Health insurance issuer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including through a health benefit plan as defined in this Section, and shall include a sickness and accident insurance company, a health maintenance organization, a preferred provider organization, or any similar entity, or any other entity providing a plan of health insurance or health benefits.

(3) "Preventive cancer screening" means healthcare services necessary for the detection of cancer in an individual including but not limited to magnetic resonance imaging, ultrasound, or some combination of tests.

(4) "Qualified covered person" means an insured or enrollee who was previously diagnosed with breast cancer, completed treatment for the breast cancer, underwent a bilateral mastectomy, and was subsequently determined to be clear of cancer.

Section 2. R.S. 46:975.1 is hereby enacted to read as follows:

§975.1. Preventive cancer screening following a bilateral mastectomy; medical assistance program

A. The annual preventive cancer screening provided for in R.S. 22:1077.1 shall be a covered service in the medical assistance program.

B. For the purposes of this Section, "medical assistance program" means the medical assistance program provided for in Title XIX of the Social Security Act as administered by the Louisiana Department of Health.

Section 3(A). This Act shall become effective on January 1, 2019.

(B) This Act shall apply to any new policy, contract, program, or health coverage plan issued on and after January 1, 2019. Any policy, contract, or health coverage plan in effect prior to January 1, 2019, shall convert to conform to the provisions of this Act on or before the renewal date, but no later than January 1, 2019.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

HB 690 Original 2018 Regular Session Stokes

Abstract: Requires coverage for subsequent cancer screening services for individuals who received a bilateral mastectomy.

Proposed law requires any health benefit plan delivered or issued for delivery in this state to include coverage for an annual preventive cancer screening for an insured or enrollee who was previously diagnosed with breast cancer, completed treatment for the breast cancer, underwent a bilateral mastectomy, and was subsequently determined to be clear of cancer.

Proposed law requires written notice of the availability of coverage for the screening to be delivered to the insured or enrollee upon enrollment and annually thereafter as approved by the commissioner of insurance.

Proposed law prohibits a health benefit plan from doing any of the following:

(1) Denying to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of proposed law.

(2) Penalizing or otherwise reducing or limiting the reimbursement of an attending provider, or providing monetary or nonmonetary incentives to an attending provider, to induce the provider to provide care to an insured or enrollee in a manner inconsistent with proposed law.

(3) Reducing or limiting coverage benefits to a patient for the preventive services performed as determined in consultation with the attending physician and patient.

Proposed law requires the annual preventive cancer screening provided for in proposed law to be a covered service in the Louisiana Medicaid program.

Proposed law applies to any new policy, contract, program, or health coverage plan issued on and after Jan. 1, 2019. Any policy, contract, or health coverage plan in effect prior to Jan. 1, 2019, shall convert to conform to the provisions of proposed law on or before the renewal date, but no later than Jan. 1, 2019.

Effective Jan. 1, 2019.

(Adds R.S. 22:1077.1 and R.S. 46:975.1)